Welcome To Our Office

PATIENT INFORMATION

Patient Name ________________________________ Age _____ Birthdate ________ Sex ____

Home Address____________________________ City, State, Zip ________________________

Home Phone _________________________ Cell/Work Phone __________________________

Email ____

Family Members Treated Here? __________________________ Referred By ______________

How shall we confirm appointments? Phone ____

(circle one and give # or address) Text ____

Email _______________________________________

MOTHER (if patient is under 18) ___Stepmother

Name ____ Home Phone ____________________

Home Address ____________________________ City, State, Zip _______________________

Work Phone ____________________________ Cell Phone ____________________________

Email ____

FATHER (if patient is under 18) ___ Stepfather

Name ____ Home Phone ____________________

Home Address ____________________________ City, State, Zip _______________________

Work Phone _________________________________ Cell Phone _______________________

Email ____

PRIMARY ORTHODONTIC INSURANCE

Insured's Name ______________________________________ Birthdate__________________

SSN ___________________________ Relationship to patient __________________________

Employer ____

Insurance Company ____ Phone ______________

Claims Address ____

Group Number __________________________ Employee ID Number ____________________

SECONDARY ORTHODONTIC INSURANCE

Insured's Name _______________________________________ Birthdate_________________

SSN _____________________________ Relationship to patient __________________________

Employer ____

Insurance Company ________________________________ Phone _______________

Claims Address ____

Group Number _____________________ Employee ID Number _____________________